

MONTANA BOARD OF RADIOLOGIC TECHNOLOGISTS

301 South Park, 4th Floor
PO Box 200513
Helena Montana 59620-0513
Phone: (406) 841-2385 Fax: (406) 841-2305
Email: dlibsdrts@state.mt.us
Website: discoveringmontana.com/dli/rts

REQUIREMENTS AND APPLICATION INSTRUCTIONS

**Incomplete applications will be returned with a statement regarding incomplete portions.
Once an application is complete, estimated time for issuance of permit or license is 5-7 days.**

RADIOLOGIC TECHNOLOGIST LICENSE

Qualifications for Licensure: Applicants for licensure must:

- ✓ Complete an ARRT approved course of study in radiologic technology approved by the board;
- ✓ Be of good moral character;
- ✓ Be at least 18 years of age;
- ✓ Not be addicted to intemperate use of alcohol or narcotic drugs; and
- ✓ Pass the American Registry of Radiologic Technologist (ARRT) examination

Fees:

- ✓ \$60.00 Application fee
- ✓ \$30.00 Original certificate fee
- ✓ \$70.00 Temporary permit fee

Application Procedures: A fully-completed application for licensure, signed and notarized, shall be submitted with the following documents:

- ✓ Photocopy of Birth Certificate or Drivers License.
- ✓ Current copy of the ARRT certificate and wallet card.
- ✓ Copy of radiology diploma from an ARRT approved program.
- ✓ Application and certification fee in the amount of \$90.00. Make check or money order payable to the Board of Radiologic Technologists. All fees are non-refundable. Do not send cash.
- ✓ Three reference letters. Applicant must have been associated or known each reference for at least a year. Relatives may not be used as references.
- ✓ If currently or previously licensed in another state or jurisdiction, a License Verification/History must be sent to this office directly from those states or jurisdictions.

Temporary Permit: A temporary practice permit may be obtained by radiologic technologist course graduates who are awaiting passage of the ARRT examination. The temporary permit expires 15 days after the date of first opportunity for examination or until notification by the examination service that the person either fails or passes the examination. Applicants for a temporary permit shall submit the following:

- ✓ Temporary permit fee of \$70.00. Make check or money order payable to the Board of Radiologic Technologists.
- ✓ Date of the next available ARRT examination

MONTANA BOARD OF RADIOLOGIC TECHNOLOGISTS

301 South Park, 4th Floor
PO BOX 200513
Helena Montana 59620-0513
Phone: (406) 841-2385, Fax: (406) 841-2305
Email: dlibsdrts@state.mt.us

APPLICATION FOR LICENSURE AS: (please check one)

- ☐ **RADIOLOGIC TECHNOLOGIST** **\$90.00**
- ☐ TEMPORARY PERMIT (Pending Results of ARRT Exam) **\$70.00**
- ☐ **LIMITED PERMIT** **\$100.00 + \$15.00 for each exam category**

PLEASE CHECK THE X-RAY CATEGORY EXAM (S) WHICH YOU ARE REQUESTING TO TAKE.
ALL APPLICANTS MUST TAKE THE GENERAL EXAMINATION.

- ☐ Abdomen ☐ Extremities ☐ G.I. tract fluoroscopy & associated
overhead films
- ☐ Chest ☐ Spine and Neck ☐ Skull

Exam Date: _____ Exam Location: _____

1. FULL NAME _____
Last First Middle
2. OTHER NAME(S) KNOWN BY _____
3. PRESENT EMPLOYER: _____
4. EMPLOYER'S ADDRESS: _____
Street or PO Box # City & State Zip Country
5. HOME ADDRESS: _____
Street or PO Box # City & State Zip Country
- PREFERRED MAILING ADDRESS: ____ Home ____ Employer
- E-MAIL ADDRESS: _____
6. TELEPHONE: (____) _____ (____) _____ (____) _____
Business Home Fax
7. SOCIAL SECURITY NUMBER _____ FOREIGN ID NUMBER _____
8. DATE OF BIRTH _____ PLACE OF BIRTH _____ ☐ Male
☐ Female
9. LICENSE NAME _____
(State your name as it should appear on the license if granted)
10. ARRT Certification: YES ☐ NO ☐
Certificate Number: _____ Date Issued: _____ Expiration Date: _____

All applicants must answer the following questions. If you answer yes, give specific details (names of organizations, dates, reasons, and outcome) on a supplement sheet.

- | | YES | NO |
|---|--------------------------|--------------------------|
| 11. Have you ever been denied the right to take this profession's licensing exam in any state?
If yes, attach a detailed explanation. | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Has a licensing agency ever taken adverse or disciplinary action against your license?
If yes, attach a detailed explanation. | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has your license ever been forfeited or surrendered? If yes, attach a detailed explanation. | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Has a complaint ever been made against you alleging unethical behavior or unprofessional conduct? If yes, attach a detailed explanation. | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever been expelled from or asked to resign from any professional organization of which you were a member? If yes, please attach a detailed explanation. | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you have criminal charges pending or have you ever pled guilty or been convicted of a crime (including a plea of no contest or deferred prosecution) relating to, or committed during the course of your professional practice, involving violence, use or sale of drugs, fraud, deceit, or theft, whether or not an appeal is pending? You may omit: (1) traffic violations, for which you paid a fine of \$100.00 or less and (2) charges or convictions prior to your 16 th birthday. If yes, attach a detailed explanation. | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever been charged with fraud, formally or informally, in any legal proceeding?
If yes, attach a detailed explanation | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you any physical or mental condition which has in the past three years adversely affected your ability to practice this profession, including but not limited to, a contagious or infectious disease involving serious risk to the public? If yes, attach a detailed explanation | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you within the last three years, used alcohol or any other mood-altering substance in a manner which adversely affected your ability to practice this profession? If yes, attach a detailed explanation. | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Has any legal or disciplinary action been filed against you relating to or during the course of your professional practice? If yes, attached a detailed explanation. | <input type="checkbox"/> | <input type="checkbox"/> |

Radiologic Technologist applicants GO TO question 24

Limited Permit applicants continue answering questions 21, 22 and 23

- | | | |
|--|--------------------------|--------------------------|
| 21. If taking the examination, do you have any physical or mental impairment(s) requiring special accommodation(s)? If yes, attach a detailed explanation. | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you ever applied for or taken a Montana Limited Permit exam?
If yes, attach a detailed explanation giving type of exam taken, date, and results. | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you ever applied for or taken a Montana Limited Permit exam in any other state?
If yes, attach a detailed explanation giving type of exam taken, date and results. | <input type="checkbox"/> | <input type="checkbox"/> |

YES NO

24. Do you currently hold a license in another state as a radiologic technologist or limited permit? ☐ ☐
If yes, provide the following information;

License Type	State	License Number	Date Issued	Current? Yes/No

YOU MUST REQUEST A LICENSE VERIFICATION FROM STATES WHERE YOU CURRENTLY HOLD OR HAVE EVER HELD A LICENSE.

25. EDUCATION:

List all colleges, universities, or course(s) which you have attended and/or completed. Include copy of all diplomas or course completion certificates.

College \ University	Course	Date attended	# of Credits	
			Hours	Months

26. REFERENCES OF CHARACTER,

List three references of reputable citizens, unrelated to the applicant having personal knowledge of the applicant's moral character. Reference letters must accompany application.

Name/Relation	Address	Business
1.		
2.		
3.		

27. Experience: Provide all locations in which you have practiced in the last five (5) years.

Name of facility		
Address	City	State
Dates: From	To	

Name of facility		
Address	City	State
Dates: From	To	

Name of facility		
Address	City	State
Dates: From	To	

Name of facility		
Address	City	State
Dates: From	To	

Name of facility		
Address	City	State
Dates: From	To	

Name of facility		
Address	City	State
Dates: From	To	

Name of facility		
Address	City	State
Dates: From	To	

AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of RADIOLOGIC TECHNOLOGISTS.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and am familiar with the applicable licensure laws of the State of Montana and instructions to applicants for licensing. I accept the rules and procedures outlined in these documents as the basis for my application.

Legal Signature of Applicant

Date

Subscribed and sworn to me by this _____ day of _____, _____

At _____
City and State

Notary Public

SEAL

For the State of

My commission expires _____

MONTANA BOARD OF RADIOLOGIC TECHNOLOGISTS

301 South Park, 4th Floor
PO BOX 200513
Helena Montana 59620-0513
Phone: (406) 841-2385, Fax: (406) 841-2305
Email: dlibsdrtts@state.mt.us
Website: discoveringmontana.com/dli/bsd

REFERENCE LETTER

Name of Applicant: _____

This form must be completed by a reference, unrelated to the applicant, who has been associated with the applicant for at least one (1) year. Three references are required. The reference letters must accompany the application.

1. How long have you known, worked or associated with this person? _____

2. Is this person, in your opinion of good moral character? _____

3. Does this person have good rapport with patients and co-workers? _____

Comments: _____

Signed

Date

Address

City

MONTANA BOARD OF RADIOLOGIC TECHNOLOGISTS

301 South Park, 4th Floor
PO BOX 200513
Helena Montana 59620-0513
Phone: (406) 841-2385, Fax: (406) 841-2305
Email: dlibsdrtts@state.mt.us
Website: discoveringmontana.com/dli/bsd

REFERENCE LETTER

Name of Applicant: _____

This form must be completed by a reference, unrelated to the applicant, who has been associated with the applicant for at least one (1) year. Three references are required. The reference letters must accompany the application.

1. How long have you known, worked or associated with this person? _____

2. Is this person, in your opinion of good moral character? _____

3. Does this person have good rapport with patients and co-workers? _____

Comments: _____

Signed

Date

Address

City

MONTANA BOARD OF RADIOLOGIC TECHNOLOGISTS

301 South Park, 4th Floor
PO BOX 200513
Helena Montana 59620-0513
Phone: (406) 841-2385, Fax: (406) 841-2305
Email: dlibsdrtts@state.mt.us
Website: discoveringmontana.com/dli/bsd

REFERENCE LETTER

Name of Applicant: _____

This form must be completed by a reference, unrelated to the applicant, who has been associated with the applicant for at least one (1) year. Three references are required. The reference letters must accompany the application.

1. How long have you known, worked or associated with this person? _____

2. Is this person, in your opinion of good moral character? _____

3. Does this person have good rapport with patients and co-workers? _____

Comments: _____

Signed

Date

Address

City

MONTANA BOARD OF RADIOLOGIC TECHNOLOGISTS

301 South Park, 4th Floor
PO BOX 200513
Helena Montana 59620-0513
Phone: (406) 841-2385, Fax: (406) 841-2305
Email: dlibsdrts@state.mt.us
Website: discoveringmontana.com/dli/bsd

LICENSE VERIFICATION

I, _____, am applying for a license to practice
_____ in the State of Montana.

The Montana Board requires verification of licensure be provided by each jurisdiction in which I hold or have held a license. I hereby authorize and request you to release any information in your files, favorable or otherwise, directly to the Montana Board of Radiologic Technologists at the address given above. Thank you for your earliest attention.

Applicant's Signature

.....
STATE LICENSURE BOARD (Please provide the following information)

Name of Licensee: _____

License No. _____ Date of Issuance: _____

Expires: _____ Is license current? _____

Licensed as: _____ Licensed by: _____

Has applicant's license ever been suspended or revoked? _____

Are there any complaints and/or legal action pending against this applicant? _____

If the answer for any of the questions is yes, please explain on the reverse of this form.

Signature

Title

Name of licensure board

Address

Telephone #

Date

BOARD SEAL